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Health Missions of the WHO

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Note by the Editor. — The ***WHO Chronicle*** is published at the end of each month in English, French and Spanish. Russian and Chinese editions are being prepared at the present time. The *Chronicle* is intended to summarize some of the activities of the Organization, without however claiming to be an authoritative record of the official views of the Interim Commission, which are set out in the ***Official Records of the WHO***. All correspondence relating to it should be addressed to the Geneva Office. Those who may wish to reproduce the text of this publication or extracts therefrom, more especially in the medical Press, are entirely at liberty to do so.

CHRONICLE OF
THE WORLD HEALTH
ORGANIZATION

VOL. I, No. 12 December 1947

THE HEALTH MISSIONS OF THE WHO

This issue of the *Chronicle* is designed to present an account of one aspect of the work of the Field Services Division of the World Health Organization—its missions. A general account of the total programme of technical aid to war-devastated countries has previously been given,[1] as have notes on the fellowship programme and aid through visiting lecturers.[2] When the Agreement between UNRRA and WHO Interim Commission was signed on 9 December, 1946, under which UNRRA granted 1½ million U.S. dollars to WHO to continue UNRRA's health work on a reduced scale in countries previously aided by UNRRA, these fifteen countries were asked by the Interim Commission in what form they would like assistance. Of the fourteen replies—Albania did not request any help—seven asked that the health missions or liaison officers established in their capitals by UNRRA should be maintained. To ensure continuity and preserve the valuable experience already gained by the staffs of the Health Division of UNRRA in these countries, immediate action was taken to transfer these small staffs—about forty including secretaries—to WHO. Later, their position was regularized either by the signing of formal Agreements or an exchange of letters with the Governments concerned.

These missions naturally differ widely in size, function and composition. Accounts of the work of the three largest—*i.e.*, those in China, Ethiopia and Greece—are included in this issue. In addition, the Interim Commission has two medical officers in Rome, assisting

[1] *WHO Chronicle* 1, 5-6, 73.
[2] *WHO Chronicle* 1, 7-8, 113.

the Italian Health Authorities with technical advice on the large public health schemes financed from the fund derived from the sale of UNRRA goods ; and single medical liaison officers in Austria, Hungary and Poland. The duties of these officers include : *(a)* acting as liaison officer between WHO and the health authorities of the country ; *(b)* assisting in the selection of, and making administrative arrangements for, doctors, nurses, etc., granted fellowships for studying abroad by WHO ; *(c)* advising on, and arranging for, the visits of specialists and lecturers in various fields requested by the Government ; *(d)* advising on and assisting the supply of medical literature, periodicals and teaching apparatus; *(e)* giving general advice and assistance, on request, to the health authorities, on public health and medical questions, including the prevention of epidemics.

The countries from which imported staff of the missions are drawn are as follows :

From the U.S.A. 16—the great majority being in China ; U.K. 5 ; Canada and Greece 3 each ; Denmark, Norway and stateless 2 each ; and one from Australia, Czechoslovakia, India, New Zealand, Palestine and Yugoslavia.

The cost of these missions, as budgeted for 1947, is approximately 708,000 U.S. dollars and the Governments themselves have made available an approximate total of 381,000 U.S. dollars in local currency for the local expenses of the missions.

It had been hoped that the permanent World Health Organization would be set up before the end of 1947, but, when it became clear that delay in ratifications would make this impossible, a further application was made to UNRRA in response to which a second donation was offered, again of 1½ million dollars, for the first nine months of 1948. The same procedure is being followed as for the 1947 grant—*i.e.*, the Governments concerned have been asked their wishes on the form in which they would like assistance in 1948 : their replies, when received and collated, will be considered by the Sub-Committee on Field Services Budget (UNRRA Funds) on 16 January in Geneva and later by the full Interim Commission, which meets on 22 January.

Thus, thanks to UNRRA's generosity, funds will be available to continue the work of these missions should the Governments concerned so request.

MISSION TO CHINA

Information is now available on the activities of the WHO Health Mission to China during the last three quarters of 1947. During and after the war, the Health Division of UNRRA had dispatched large quantities of medical supplies to China and its personnel had provided medical and technical assistance to the Chinese National Health Authorities. When UNRRA's activities came to an end, the task of providing this assistance was transferred on 1 April 1947 to the WHO Interim Commission by an arrangement signed by the two organizations in December 1946.[1]

China, like every country suffering from the results of a long and devastating war and from enemy occupation, was confronted at the end of hostilities with three main problems : lack of funds, lack of qualified personnel, and lack of active scientific contact with the rest of the world. The result was that the authorities could not organize the badly needed campaigns against epidemic diseases—malaria, schistosomiasis, kala-azar, tuberculosis—threatening the population.

The functions of the WHO Health Mission were to train qualified Chinese personnel and to educate them in recent developments in medical knowledge. A number of experts were assigned to the various Chinese health authorities to offer guidance in their particular fields. Thus, the Mission for the year 1947 comprised a group of medical personnel, including two epidemiologists, a pædiatrician, two surgeons, two orthopædic surgeons, a tuberculosis expert, two ophthalmologists, a bacteriologist, a radiologist, a gynæcologist, a neurologist, and an expert on quarantine measures. Sanitary engineers, nursing consultants, and X-ray technicians also formed part of the Health Mission. Their work fell mainly into two categories : the control of epidemics by work in the field, and the training of Chinese staff.

Epidemic Control

Plague. — The focus of plague in the south-east covering large parts of the provinces of Fukien, Chekiang and Kiangsi was almost completely kept under control by the South-Eastern Plague

[1] See *WHO Chronicle*, **1**, 3-4, 48 (1947).

Prevention Bureau with its headquarters in Foochow (Fukien province). A WHO epidemiologist was assigned to this Bureau.

An outbreak during the spring of 1947 in Nanchang, which had hitherto been free of plague, raised serious problems, as it involved a threat to the entire Yangtze valley. A survey of all infected areas was made by the Health Mission, which presented recommendations for an effective campaign including the necessary quarantine measures. A special anti-plague training course for 18 medical officers and senior staff was held in Nanchang from 19 to 30 May. A city rat-control programme by various methods gave satisfactory results. As baits were generally more easily available than traps, rat control could best be intensified by extending the use of certain rodenticides. But trapping gave such unsually good results that it was decided to use traps as a routine measure in houses baited the day before. The incidence of plague-infected rats was never great and the occurrence of only one human case of plague was highly encouraging.

A plan for the extension of anti-plague work in Nanchang was drawn up, involving a city-wide application of DDT combined with inoculation in October and November, and a second trapping campaign.

No reports are available on the next most important plague focus, that in the north-eastern provinces, as this region is partly within the area controlled by the Communist armies. It appears, however, from non-official information, that no serious outbreak of plague occurred during last winter and spring.

Kala-azar. — Kala-azar is, in the opinion of many people familiar with China, one of the most urgent of its medical problems. It has been estimated that the case fatality-rate is almost 100 per cent and that the present number of cases is from two to three millions. Recent information from the Shantung, Hopei-Kiangsu area, controlled by Communist authorities, reported about 500,000 cases.

The measures taken against the disease were not, generally speaking, satisfactory, mainly because the kala-azar belt coincides with the civil war fighting-zones. Any serious action to combat the disease in these areas is impossible, as personnel, funds, transport facilities and administrative stability are all lacking. There are several centres of anti-kala-azar activities, but they are confined almost exclusively to larger cities and hospital clinics, and it is

questionable whether the present organization reaches more than 50,000 cases.

The Chinese authorities have made efforts to improve the situation, but they are confronted with a gigantic task. The WHO China Health Mission has actively co-operated with the Chinese health authorities in this work although its present possibilities are limited. A course for training technicians was started and ten students enrolled. Plans were drawn up for a treatment and research centre, and of a total of six buildings planned, two Quonset huts have already been constructed. This is clearly one of the fields in which the local administration needs considerable assistance. The kala-azar problem in China is one of the best examples showing the need for international co-operation in the solution of some of the major health problems.

Tuberculosis. — The anti-tuberculosis programme consisted mainly of surveys by mass miniature radiography and of the distribution and installation of the equipment previously brought to the country by UNRRA. Mass surveys were organized in Peiping, Shanghai, Nanking and Tientsin, with the collaboration of the Chinese authorities. Arrangements have also been made with the Shanghai Board of Education authorities to perform tuberculin tests and radiological examinations of several thousand children in order to find enough tuberculin negatives on whom to carry out a controlled study with the lyophilized BCG vaccine brought from Denmark by the WHO Mission. It was proposed to the National Institute of Health that six other centres for mass chest surveys should be installed by February 1948 and eight further centres after that date. Three Chinese doctors have been sent to Copenhagen for special training in the preparation, application and control of BCG vaccine.

Cholera. — Cholera, fortunately, did not present a great problem this year in China. In Shanghai, for example, the total number of cases reported to 30 September 1947 was 37, less than 1 per cent of the incidence for the same period last year. In the opinion of the WHO expert, the low incidence was due partially to the early inoculation programme, to the more widespread use of piped water supplies, to the reduction in the fly population through the use of DDT, and perhaps most of all to the fact that few cases were imported into the city.

In Nanking, pioneer research was carried out on standardization of cholera vaccine in human subjects, in which the antibody response to the injection of vaccines prepared by different methods was determined.

Other Epidemic Diseases. — Malaria, smallpox, gastro-intestinal infections, schistosomiasis and ankylostomiasis were prevalent, but unfortunately it was not possible for the Chinese authorities to take new and active measures to protect the population. The chief obstacles to their control are the lack of funds and the lack of properly qualified personnel.

Training of Personnel

Perhaps the most important task of the WHO Health Mission to China was the training of medical and public health personnel, and much of the time of the experts was devoted to this activity. The field covered was very wide: physicians were trained in almost every aspect of clinical and preventive medicine ; nurses and sanitary engineers were trained in hospital and public health techniques.

The main training-centres were Nanking and Canton, where two groups of experts were stationed, while individuals were also active in several of the larger medical centres.

In Nanking, the WHO experts were assigned to the Central Hospital and to the National Institute of Health, and have participated actively in the attempt to make the Institute an efficient centre for medical research and training. The training included surgical technique, radiology, bacteriology, ophthalmology, psychiatry and pædiatrics, and consisted of lectures, demonstrations of experimental work and of the new diagnostic and therapeutic methods, as well as guidance in practical public health work. Special lessons in the supervision of rural field practice were given to senior students. A clinical nursing consultant gave advice on nursing procedure.

In Canton, the WHO experts have been assigned to the Canton Central Hospital to co-operate within the framework of the recently established Medical Centre in Canton. Expert assistance was offered in the fields of gynæcology and obstetrics, surgery, ophthalmology, radiology, public health and hospital nursing.

In addition to Nanking and Canton, one ophthalmologist worked in Chengtu and a nursing consultant in Lanchow, Mukden and

Formosa, training local personnel and demonstrating modern techniques. Despite great difficulties, it was possible to assign a WHO orthopædic surgeon to the Communist-controlled area, and this mission has yielded very satisfactory results. In many cases the WHO experts worked in the closest collaboration with Chinese doctors and many scientific papers bear witness to the success of this co-operation. China, a country whose normal development has been prevented for at least 15 years, is handicapped by a grave poverty in teaching personnel, and the assistance afforded by the WHO Interim Commission in continuation of the work of UNRRA has proved of great value in the rehabilitation of the country.

Other Activities

Among other activities of the WHO Mission should be mentioned the expert assistance given to the National Institute for Biological, Chemical and Pharmaceutical Production. This institution was founded by the National Government shortly after the Japanese surrender to take over existing Japanese pharmaceutical factories in China, to continue pharmaceutical production at Government-regulated prices, and to supply the health administration with the most widely needed basic products such as penicillin, sulpha drugs, DDT, glucose and phenol. A WHO pharmaceutical and chemical engineer was assigned to the N.I.B.C.P.P. to provide the necessary technical advice.

The Mission also granted 35 fellowships to Chinese doctors to study newly-developed techniques abroad. In addition, travelling fellowships were reserved for six or eight Fellows who will be sent abroad for three to four months' studies in port quarantine.

MISSION TO ETHIOPIA

The WHO Mission in Ethiopia has been operating since 1 January 1947, as a continuation of the health activities of the UNRRA Mission in that country. In March, the activities and position of the Mission were regularized by the signing of an Agreement between the Interim Commission and the Imperial Ethiopian Government.

It might also be mentioned that Ethiopia was among the first countries to ratify the Constitution of WHO.

The health needs of Ethiopia are almost limitless. With not a single indigenous doctor or nurse for a population of about 12 millions, dependence on foreign aid is essential for some years. There are at present some 70 foreign doctors in the country, of whom 42 are in Addis Ababa, and about the same number of nurses. A committee on medical education recently made what it considered to be a conservative estimate of the needs of the country and put these at about 1,200 medical assistants, 300 nurses and 2,000 dressers, and 1,200 sanitary inspectors : altogether, with other auxiliary workers, about 5,000 technically trained persons are required.

The incidence of disease and the nature of epidemic outbreaks, at least in the provinces, are largely unknown and medical opinion differs widely even on such questions as the relative size and importance of the problems in tuberculosis and venereal diseases. Multiple infections are common.

In the hospitals, elementary equipment is often lacking. Thus a female "dresser", in one of WHO's nursing classes which was shown a film on "Bathing the Patient", commented that "we should like to give care like that to our patients but we do not have a wash-basin, pan or pitcher in our ward ", and this was confirmed by inspection. Sanitation is another vast problem, but fortunately food is abundant and the diet well balanced.

Faced with these problems, the WHO Mission, in the closest collaboration with the Vice-Minister of Health and his advisers, decided to concentrate on three main tasks : to give elementary training in nursing and sanitation to dressers and sanitary officers ; to assist the Municipality of Addis Ababa in sanitation ; and to assist the Ministry of Health in investigating and dealing with epidemics in the outlying provinces. These tasks have tried the small staff—originally two doctors, three nurses and a secretary—to the utmost.

Elementary courses for dressers in four hospitals have been completed and a more advanced course begun at the Menelik Hospital. Eighty-five dressers have now received official certificates as a result of examinations by an independent examining board. Help has been given in establishing courses for dressers at hospitals in outlying provinces and a *Manual* in Ethiopian for the training of dressers has been produced. All reports show the great relief

afforded to the inadequate imported nursing staffs of Government and mission hospitals by even the most elementary training of local dressers.

Two elementary courses for sanitary inspectors have been completed. A selection of the best candidates from both courses will be given more advanced secondary training. Both in the courses for dressers and for sanitary officers, and in schools and at public meetings, much use has been made of cinema films for demonstration purposes.

Two of the three nurses resigned for personal reasons in April and only one has been replaced, but there is an urgent need for another nurse, since the training of the dressers can be kept up to the mark only by constant supervision in the wards. The deputy Chief of Mission, a British medical officer with long experience in the Colonial Service, acted as Medical Officer of Health to the city of Addis Ababa until he resigned in September for health reasons. He was replaced in October by an American sanitary engineer on loan from our Greek Mission and the post of sanitary inspector —vacant since the beginning of the year—was filled at the same time by a Greek who had previously worked with UNRRA and the WHO Mission. The elementary nature of the public health problems would seem to call for this strengthening of the sanitation, rather than the medical staff—and the Ministry of Health has been particularly insistent on this point. In the recent training of sanitary officers, questions of water protection and disposal of excreta have been stressed, in view of the menace of the importation of cholera from Egypt. Plans are being made for some simple sanitation programmes, more in the nature of demonstrations, and a study of various DDT preparations which was made for the Ministry of Health showed that an initial saving of 37,400 Ethiopian dollars could be made on the cost of solvents alone. Other activities included DDT dusting of 15,000 operatives in a cotton-mill and industrial schools.

In addition to the investigation of epidemics of malaria, typhus and meningitis in various parts of the country, other medical activities have included membership of committees on the distribution of medical supplies, on medical education and on measures of protection against cholera. The chief nursing adviser has acted as secretary to the newly re-established Ethiopian Red Cross and gave much time to its activities.

So far, only the surface of the almost virgin soil of Ethiopian health problems has been scratched. The new grant from UNRRA for 1948 should, if the Government wishes it, allow these unobtrusive yet essential activities to continue and perhaps expand.

MALARIA IN GREECE

Malaria has been a scourge in Greece since the days of Hippocrates. Out of a population of six to seven millions, it has been estimated that the disease has been responsible over many years for a total annual number of cases exceeding one million, with an average of 5,000 deaths.

The modern conceptions of the prevention and control of malaria were slow to develop in Greece, and there was little radical improvement in the situation until 1946, when a nation-wide campaign against anopheles, based on anti-imago as well as antilarval measures, with the use of DDT, led to spectacular results.

The campaign was started by the Greek Government with the technical and material assistance of UNRRA. The Athens School of Hygiene, under its Director, Professor LIVADAS, was responsible for the general administrative and malariological aspects, while the Malaria Control Section of UNRRA, under Colonel D. E. WRIGHT, Chief Sanitary Engineer, dealt with the engineering and technical side of the work. Seven hundred thousand houses were sprayed with DDT by hand, and 96,000 acres of malarious swamps from aeroplanes. The results were spectacular, and brought about an immediate decline in the death rate. Blackwater fever, too, declined, and no cases were reported from areas where the disease had previously existed. Malaria infections in 1946 revealed a remarkably low proportion of *P. falciparum* infections, showing that transmission in that year was at a low level. As a secondary consequence, it was observed that flies, a plague in Athens since ancient times, completely disappeared during the summer. The DDT campaign against malaria appeared to have even an unsuspected economic consequence, as the yield of olive groves was increased by 25 per cent in some regions, owing to the destruction of the *Dacus* fly by the insecticide sprayed.

When UNRRA ended its activities, some of its functions, including collaboration in the malaria campaign in Greece, were taken over by the Interim Commission of the WHO.

The anti-malaria campaign of 1947 was carried out by the Greek Government under the direction of the Athens School of Hygiene with the co-operation of the Interim Commission Field Mission headed by Dr. J. M. VINE. The campaign mainly consisted of house-spraying and larval control by hand and by air.

The *house-spraying* was applied to the buildings of every town, village or hamlet in malarious areas with a population not exceeding 6,000 inhabitants. All premises were treated, the walls and the ceilings being systematically sprayed with DDT in the form of a 5-per-cent emulsion, prepared locally by diluting the 26-per-cent concentrate with water.[1] Two grammes of DDT were used per square metre. A total of 5,266 communities was thus treated with the insecticide up to 1 October. In the towns with a population over 6,000, house-spraying was limited to the buildings on the outskirts of the town. In the large towns of the country —as, for example, Athens—house-spraying was limited for general insect-control to buildings such as slaughter-houses, dairies, restaurants, as well as markets and garbage dumps.

The *larval control* was carried out both by hand-spraying, repeated every 12 days with a 0.1-per-cent DDT emulsion, one litre per 50 square metres (0.02 gramme of DDT per square metre) and by air-spraying. During 1947 there were 12 air-spraying centres and a fleet of 17 aircraft was employed. The 20-per-cent solution of DDT in Velsicol was used at the rate of half-a-pint per acre—*i.e.*, about 0.012 gramme of DDT per square metre repeated every 15 to 17 days. It was calculated that an aeroplane sprayed 17 acres (ha. 6.8) during a one-minute flight and that the cost of spraying 10,000 square metres was $0.40 by aeroplane against $3.60 by hand.

It is believed that, with the exception of villages in the active fighting-zones or in the hands of the guerillas, every community in Greece in the malaria-endemic area has been protected during 1947 either by residual spraying of DDT or by larvicidal methods or by a combination of the two. A plan for the collection of blood samples from selected villages using malaria inspectors specially trained to

[1] In stables, out-houses, warehouses, etc., the DDT was employed in the form of a 5-per-cent Diesel oil solution, prepared by diluting the 20-per-cent concentrate in Velsicol, for air-spraying.

take blood smears has been put into operation. When the results of this collection are known and analysed, it will be possible to make a fairly accurate estimate of the results of the 1947 campaign against malaria in Greece.

TUBERCULOSIS IN GREECE

For nearly two years, Dr. J. B. McDOUGALL was UNRRA Consultant in Tuberculosis in Greece. In an article of 100 pages, "Tuberculosis in Greece", which will appear in the first number of the *Bulletin of the World Health Organization*, he recounted his personal impressions both of the problems confronting him and his colleagues and of the methods used to overcome them. This account of the difficulties involved in the reconstruction of an adequate working scheme for the diagnosis and treatment of tuberculosis presents, particularly when read in conjunction with the previous article on malaria, a vivid picture of the magnitude of the task confronting the WHO Mission in Greece. But Dr. McDougall's article—aptly subtitled "An Experiment in the Relief and Rehabilitation of a Country"—has more than a local interest. The information gained from the experiences of the UNRRA Tuberculosis Section in Greece will be of great help to any organization, international or other, which decides to assist the tuberculous in countries which are unable, through no fault of their own, to meet their full obligations.

The story begins in the spring of 1945, when UNRRA was asked to survey the tuberculosis requirements of Greece. The country had been devastated by four years of German, Italian and Bulgarian occupation and several months of civil war. It was reliably estimated that 30 per cent of the population was undernourished. Public-health organization was almost non-existent. The first necessity was a preliminary appraisal of the situation, and Dr. McDougall has grouped his broad general conclusions under fourteen main points. Summarized briefly, the survey revealed that only the crude outline of a tuberculosis scheme existed, that there were practically no full-time specialists, that many sanatoria had been damaged or requisitioned during the war, that those sanatoria which were functioning were short of everything from kitchen utensils and

bed-clothes to X-ray equipment, that the patients frequently refused to be discharged, and that the State expenditure on tuberculosis work was quite inadequate.

It was decided that the first step should be to open as many beds as possible in institutions only slightly damaged, so as to replace the 1,200 beds lost during the war. The next step was to bring existing dispensaries up to date with equipment, and to introduce as much radiology as possible. In this connexion, Dr. McDougall pays tribute to the enthusiasm of the Greek doctors for mass-radiology, an enthusiasm which, until they were adequately trained in its use, he had to restrain. Lastly, it was considered advisable, in view of the important part in public health played in Greece by voluntary associations, to establish a National Tuberculosis Association of Greece on the lines of American, British and Scandinavian counterparts. The scheme was not over-ambitious ; it was an emergency measure for a country in distress, and was intended to lay down sound principles on which the future national scheme could be based.

May 1945 saw the first steps taken to introduce the scheme. Twelve static X-ray sets, 3 mass-radiological sets, 6 artificial pneumothorax machines, 100,000 large, and an equal number of miniature, films, blood sedimentation sets, and surgical instruments were requested, and 5 teams were recruited. By the end of September all these teams were in Greece and working in their allotted areas. That month saw too the formation of a Tuberculosis Department by the Greek Ministry of Hygiene to take over the work when UNRRA should leave. In August 1945, the first mass-radiological centre was opened in Athens with equipment provided by the Greek War Relief Association and, as the result of its work, the first preliminary estimates of the incidence of tuberculosis in Greece were obtained. These led to the deduction that the total number of cases of pulmonary tuberculosis in Greece amounted to 485,750.

At this time there were no more than 4,000 odd beds available for the treatment of all forms of tuberculosis and it was suggested that emergency use should be made of prefabricated buildings for temporary institutional accommodation and for dispensaries. Difficulties and problems rapidly accumulated ; administrative disorganization, economic inflation, lack of co-ordination between the various voluntary societies, as well as purely medical problems such as non-pulmonary tuberculosis and tuberculosis in children.

UNRRA had come in a purely advisory capacity, but experience showed that in tuberculosis work efforts would be limited unless some executive power were given.

The primary necessities were funds and equipment, and in this connexion visits to England and the United States proved useful. A study of the whole problem led to the conclusions that the Greek War Relief Association was likely to be the most important single-organization operating in all branches of public health, and that the amelioration of tuberculosis in Greece could be based only on a long-term policy, with the Greek Government, the Greek War Relief Association and all other agencies working in the very closest co-operation. Despite reverses, despite the increasing complexity of administrative machinery, the work progressed. Occupational therapy was inaugurated on a small but increasing scale. More sanatoria were opened, more beds made available in others. Mass X-ray centres, anti-tuberculosis propaganda, dispensaries — all figured in the programme of work undertaken, which should be studied in Dr. McDougall's article itself. The final phase came with the acceptance by the Interim Commission of the WHO of the responsibility for the maintenance on a reduced scale of the malaria and tuberculosis programmes of UNRRA after 31 December 1946. The achievements of the 21 months are impressive, and for full details we can only refer those who are interested to the article itself. Briefly, by December 1946, 1,728 additional beds had been made available and a further 2,000 planned for 1947 ; 26 dispensaries had been opened and a further 18 planned, while over 50,000 " healthy " persons had passed through three mass X-ray centres.

This was the first experiment of its kind in tuberculosis to be conducted by a group of international specialists in a foreign country. Dr. McDougall and the Tuberculosis Section, composed of one Central Consultant, five Area Consultants, five tuberculosis nurses, two technicians and five clerk-interpreters, had the satisfaction of knowing that their work on behalf of the tuberculous in Greece would continue and that the plans made would be followed up by some, at least, of the tuberculosis consultants who had already done so much valuable field-work.

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report: POST-WAR DEATH RATES

An article on post-war mortality rates by Knud Stowman, Epidemiological Consultant to the WHO, published in the latest number of the *Epidemiological and Vital Statistics Report*[1] will undoubtedly surprise those readers who are not specialists in this particular field; for the figures presented by the author show that, despite two wars and a deadly influenza epidemic, mortality is decreasing, against all expectation, in practically every country. Here are some of the facts quoted by the author.

The first fact revealed by a glance at the mortality figures is that the low-death-rate area of the world remains essentially the same as before the war. It consists of the Scandinavian countries with Finland, the Netherlands, United Kingdom, Switzerland, Canada, the United States, Argentina, the Union of South Africa (white population), Australia and New Zealand, which all had death rates from 8.5 to 12 per 1,000 inhabitants in 1946 as they had before the war. To this list must now be added Italy, where the death rate for the first time was down to 12 per 1,000 in 1946. Judging from the fragmentary information available, Germany, on the other hand, can no longer be counted among the low-mortality countries.

The Netherlands held the world record for low mortality with a 1928-1938 median of only 8.8 per 1,000. In 1946, the death rate, after a temporary increase during the war years, dropped again to 8.5, a minimum which had been touched only once before: in 1938.

Sweden, Norway and Denmark had death rates from 9.2 to 10.9 per 1,000 in 1946, all lower than the pre-war medians. Finland which, contrary to Denmark, had a heavy war-mortality reaching nearly 20 per 1,000 in 1940 and 1941, reached the figure of 11.6, the lowest ever experienced in that country. France, too, registered in 1946 the lowest death rate it ever experienced, namely 13.4 per 1,000. Belgium had a general death rate of 13.2, Switzerland of 11.2 in 1946, both comparing favourably with pre-war years. In Italy, the death rate fell from 17.4 per 1,000 in 1921-1925 to 13.4 in 1939, after which it dropped to 12.0 per 1,000 in 1946. There has been a somewhat similar decrease of mortality in Spain and Portugal, but the rates remain higher than in Italy (14.7 for Portugal and 12.1 per 1,000 in Spain). The latter figure, however, would appear to be slightly under-estimated.

It is unfortunate that mortality data are scanty for Central and Eastern Europe, as this area includes some of the countries which suffered most severely from the war. It may, however, be stated that Austria is nearly back to its pre-war mortality with a death rate of 13.4 per 1,000 in 1946, as

[1] 1, 5, October 1947.

against 24.8 per 1,000 during the previous year. In Hungary, the 1946 death rate was 14.1, which is about the same as the average for 1936-1943. In Czechoslovakia (excluding the German population, which was being evacuated), the death rate was 13.7 per 1,000 in 1946 as against a pre-war median of 13.5. In Rumania, where the death rate has always been high, it was 18.0 per 1,000, as against a pre-war median of 20.2. In Bulgaria, the mortality rate for 1946 was 13.7 per 1,000 as against a median of 15.6 per 1,000 for the years 1928-1938. In the United States and the British Dominions, the war had no significant effect upon the civilian mortality. The 1946 death rates were 10.1 for the United States, 10.0 in Australia, 9.7 in New Zealand, 8.8 in the Union of South Africa (white population), and 9.2 in Canada. In temperate South America, Argentina had a death rate of 10.6 in 1944. Considerably higher death rates are encountered in the tropical and semi-tropical countries of Latin America, although there has been a definitely downward trend. Thus, in Mexico, the rate fell from 23.4 in 1936-1940 to 19.4 in 1946, in Venezuela the death rate decreased from 17.8 in 1936-1940 to 15.0 in 1946, and in Chile from 23.2 in 1936-1940 to 17.2 in 1946.

The registration area of India gave a death rate of 17.5 per 1,000 in 1946 as against 22.2 in 1936-1940 and 24.1 in 1944. Only Japan is a notable exception, for the death rate, which was 20.6 per 1,000 in 1921-1930 and 16.4 from 1939-1944, rose to 21.4 in 1946.

There can be little doubt that the standard of living as apparent in food, housing, fuel and clothing supply is lower now in Europe than it was before the war. The favourable mortality situation existing in most places where information is available is therefore somewhat of a surprise. The absence of serious epidemics and the relatively high state of public-health work and of social services count, of course, for something, but there seem to be still other factors at work. It is more than likely that the greater degree of individual healthiness attained between the two world wars has produced an increased resistance. How long that stamina can last if severe hardships should be prolonged remains to be seen.

The article is accompanied by statistical tables giving the general death rates in some countries, the general death rates in large towns of Europe, the general death rates in some large towns outside Europe and tuberculosis mortality.

Official Records of the WHO

The *Official Records of the World Health Organization* contain the summary records of the meetings of the principal organs constituting the World Health Organization, together with the documents considered at these meetings.

With the exception of No. 2, Nos. 1 to 5 have either already appeared or will have appeared before the end of 1947. No. 2 is to be devoted to the discussions and Final Acts of the International Health Conference, held in New York in June 1946, and its publication has been postponed pending the issue by the United Nations of the Report of the Conference.

No. 1, which has been recently issued, contains the Minutes and relevant documents of the meetings of the Technical Preparatory Committee for the International Health Conference. This Committee, set up by the Economic and Social Council of the United Nations, met in Paris from 28 March to 5 April 1946.

No. 3 contains the Minutes and documents of the first session of the Interim Commission, held immediately after the International Health Conference in New York in July 1946; No. 4, those of the second session held in Geneva in November 1946; and No. 5, the records of the third session held in Geneva in April 1947. No. 6, containing the records of the fourth session which took place in Geneva in August 1947, will be submitted in proof form for approval to the fifth session of the Interim Commission.

Subsequent numbers will contain the records of the final sessions of the Interim Commission, and, later, of meetings of the World Health Assembly and of the Executive Board.

NOTES AND NEWS

Venereal Diseases

Four members have been appointed to serve on the Expert Committee on Venereal Diseases which is now being formed. They are Dr. W. Coutts, Chief, Department of Social Hygiene, *Dirección General de Sanidad*, Santiago de Chile; Professor M. Grzybowski, Clinic of Dermatology, University of Warsaw, Poland; Dr. J. F. Mahoney, Director, Venereal Disease Research Laboratory, United States Public Health Service; and Dr. G. L. M. McElligott, Medical Officer in charge of Venereal Disease Division, Ministry of Health, London.

WHO Representation

During the period between 10 November and 20 December, the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations:

Second Session of the Inter-American Conference on Social Security, Rio de Janeiro, 10 November.

Fourth General Congress of the International Relief Union, Geneva, 25-27 November.

103rd Session of the Governing Body of the International Labour Organization, Geneva, 11-15 December.

Executive Board of the International Children's Emergency Fund, Lake Success, 2 December.

Preliminary Meeting of Experts on Housing in Tropical and Sub-Tropical Areas, Caracas, 2 December.

Forthcoming Meetings

The Interim Commission will hold its fifth session at the Palais des Nations, Geneva, from 22 January to 7 February 1948.

Now that 21 States Members of the United Nations have ratified the WHO Constitution, it is anticipated that the First World Health Assembly will be held some time in the spring or early summer of 1948. The interim phase of the WHO is drawing to a close. The next step is the establishment of the Organization proper, and the forthcoming meeting of the Interim Commission should form a landmark in the evolution of a single international health organization. Members will have to consider the activities of the Interim Commission and to formulate specific recommendations to the Assembly. Suggestions will be made on the methods of combating on an international scale those diseases—tuberculosis, malaria, venereal diseases, influenza—which constitute an ever-present threat to international public health. Other public-health problems such as quarantine measures, public-health administration and education, habit-forming drugs, insulin supply, infant mortality, will be discussed. Finally, organizational problems, the relations of the WHO with other organizations, the site of the headquarters, the budget for 1948 and 1949, will also be considered.

The Sub-Committee on the Field Services Budget will meet in Geneva on 16 January 1948.

The Committee on Administration and Finance will meet in Geneva on 19 January 1948.

Technical Meetings.

The Expert Committee on Venereal Diseases will meet at Geneva, Palais des Nations, on 12 January 1948.

The Expert Committee on Tuberculosis will meet at Geneva, Palais des Nations, some time in February 1948. The precise date will be announced later.

The Expert Committee on Malaria will meet at Washington, D.C., some time in May 1948. The precise place and date of the meeting will be announced later.

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